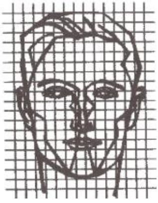

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Dental/Medical Information Release Form

Name: ________________________________ Date: ___________________

Release of Information

Please check appropriate line

__ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

___ Spouse- Name _________________________________

___ Child(ren)-Name(s) ________________________________

___ Other - Name___________________________________

_____ Insurance Company

_____ Dentist

_____ Medical doctor

___ Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing

Signed : _______________________________

Date: _________________________________